WELCOME TO SEONHO HA PROSTHODONTICS

2970 W. Olympic Blvd. #201, Los Angeles, CA 90006
Phone: (213) 365 - 1008
Fax: (213) 740 - 8142

Today's Date ______/______/________

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be strictly confidential.

GENERAL INFORMATION

PATIENT NAME (LAST, FIRST MIDDLE)				BIRTHDATE
				/ /
TITLE	**GENDER**		**PREFERRED METHOD OF CONTACT**	
☐ DR. ☐ MR. ☐ MRS. ☐ MS.	☐ MALE	☐ FEMALE	☐ HOME ☐ WORK ☐ CELL ☐ EMAIL	
ADDRESS	**CITY**		**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**		**CELL PHONE**	
EMAIL ADDRESS	**SOCIAL SECURITY NO.**		**DRIVER'S LICENSE**	
EMERGENCY CONTACT (OR PARENT'S NAME IF MINOR)	**RELATIONSHIP**		**EMERGENCY CONTACT PHONE NUMBER**	
EMPLOYER			**OCCUPATION**	
EMPLOYMENT ADDRESS	**CITY**		**STATE**	**ZIP CODE**

INSURANCE INFORMATION

SUBSCRIBER INFORMATION	PRIMARY	SECONDARY
NAME		
RELATIONSHIP (IF DIFFERENT)		
INSURANCE COMPANY		
GROUP / POLICY NUMBER		
SOCIAL SECURITY NUMBER		

REFERRAL

REFERRED BY:	NAME
☐ PATIENT ☐ DENTIST / DOCTOR ☐ OTHER: ____________________	

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am financially responsible for all charges, regardless of insurance coverage.

_______________________________________ Signature

____________________ Date